Chapter VI

COMPLAINT RECEIPT AND SCREENING: CENTRAL COMPLAINT UNIT

A. Overview of Function and Updated Data

The Medical Board's Central Complaint Unit (CCU) is responsible for receiving, acknowledging, screening, and processing all complaints and reports the Medical Board receives about the medical care provided by and conduct of California physicians.

CCU is located in Sacramento, and is currently staffed by two managers, 15 analysts, four management services technicians, and a number of support staff. CCU is supported by a cadre of physicians ("medical consultants" or "MCs") under contract with the Unit who review complaints and medical records to assist in determining whether complaints should be referred for formal investigation. As of October 2003, a deputy attorney general from the Health Quality Enforcement Section of the Attorney General's Office and a supervising investigator from MBC's field investigations staff joined CCU; their roles are described below.

As noted in Chapter V, CCU is presently divided into two sections — the Quality of Care Section (which handles complaints related to diagnosis and/or treatment provided by a physician to a patient in the context of the physician/patient relationship) and the Physician Conduct Section (which handles all other complaints).

Quality of care cases. In order to analyze a quality of care (QC) complaint, CCU must procure the medical records of the patient from the complained-of physician (and often other treating physicians and institutions), which are subject to the physician-patient privilege and may not be released by the physician absent the patient's permission. Thus, CCU must secure the signature of the patient on a "release" or waiver of the privilege and request all relevant medical records on the patient, which may include charts, X-rays, laboratory test results, photographs, invoices, and correspondence. CCU may also request that the physician provide a summary or explanation of the care and treatment provided to the patient. Once CCU receives those medical records and other documents, the entire file is reviewed by one of CCU's medical consultants, who determines whether

there has been a departure from the applicable standard of care and recommends whether the case should be closed (because it reveals no violation or involves conduct that does not merit disciplinary action) or referred to the appropriate regional field office for formal investigation.

Physician conduct cases. Non-quality of care cases (also called "physician conduct" or "PC" cases) may involve alleged sexual misconduct, drug or alcohol abuse, false advertising, fraud, or criminal activity (among others). If the proper analysis of these cases requires patient medical records, CCU will secure a waiver, request the records, and turn the matter over to a medical consultant for a recommendation on whether the case should be closed or go forward. If not, CCU will process the case as appropriate depending on the type of case and sufficiency of the evidence.

Recent changes to CCU. The *Initial Report* provides a detailed description of CCU's complaint processing function which is not repeated here.[101] However, the reader is reminded of several relatively new changes to CCU functioning:

■ ***Case processing priorities***. Effective January 1, 2003, SB 1950 (Figueroa) enacted section 2220.05, which declares that "[i]n order to ensure that its resources are maximized for the protection of the public, the Medical Board of California shall prioritize its investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously. Cases involving any of the following allegations shall be handled on a priority basis, as follows, with the highest priority being given to cases in the first paragraph:

(1) Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public.

(2) Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor. . . .[102]

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[101] *See Initial Report*, *supra* note 13, at 75–83.

[102] Business and Professions Code section 2220.05(a)(3) emphasizes that a physician prescribing, furnishing, or administering controlled substances for intractable pain consistent with lawful prescribing practices shall not be prosecuted for excessive prescribing.

(4) Sexual misconduct with one or more patients during a course of treatment or an examination.

(5) Practicing medicine while under the influence of drugs or alcohol."

Thus, effective January 1, 2003, CCU staff who initiate complaints into MBC's computer system assign a priority code to each case according to the section 2220.05 priorities. In MBC parlance, section 2220.05 "priority cases" are called "U1" or "U3" or "U5," depending on which subsection of 2220.05(a) is applicable. For cases not falling into a section 2220.05 priority category, CCU continues to utilize the pre-existing prioritization categories of "urgent," "high," and "routine." In addition, U1–U5 priority cases are physically "red-tagged" so that CCU analysts can visually distinguish them from the rest of their caseload.

■ ***"Specialty review" requirement***. Also effective January 1, 2003, SB 1950 (Figueroa) added section 2220.08, which prescribes a specific review process for quality of care cases in CCU. The statute requires CCU — before referring most QC complaints to the field for investigation — to ensure they have been "reviewed by one or more medical experts with the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required." Section 2220.08 specifies that such "specialty review" must include a review of relevant patient records, a statement or explanation of the care and treatment provided by the subject physician, any additional expert testimony or literature provided by the subject physician, and any additional facts or information requested by the medical expert reviewers that may assist them in determining whether the care rendered constitutes a departure from the standard of care. The specialty review requirement has required CCU to recruit and train new medical consultants in a number of different specialties and subspecialties so that QC complaints and reports can be reviewed by a physician with relevant expertise.

■ ***Additions to CCU***. Effective October 1, 2003, two persons were newly assigned to CCU. The half-time assignment of an HQE deputy attorney general (DAG) to CCU represents MBC/HQE's long-overdue implementation of Government Code section 12529.5(b)'s requirement that HQE "assign attorneys to assist the division . . . in intake . . . . Attorneys shall be assigned to work closely with each major intake and investigatory unit . . . to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations."[103] At the same time,

[103] Government Code section 12529 *et seq*. was enacted in 1990 and became effective on January 1, 1991. It creates the Health Quality Enforcement Section in the Attorney General's Office and requires the Attorney General to "ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against licensees" of the Medical Board. Section 12529.5 requires HQE to station deputies attorney general on location at every major intake

MBC assigned a supervising investigator to work full-time at CCU — such that CCU now has built-in legal and investigative expertise to assist in the processing and review of complaints.

Initially, the skills of these two professionals were not well integrated into the Unit. By September 2004, however, their roles had expanded considerably. The CCU DAG reviews all medical consultant-reviewed quality of care cases in which a simple departure has been found and all medical consultant-reviewed cases in which there is a split of opinion between MCs, has become involved in a few cases in which subject physicians or health care institutions have failed to produce requested medical records, and has reviewed and assisted in revising the *CCU Medical Consultant Procedure Manual* and various CCU forms. The CCU supervising investigator now reviews QC complaints that are proposed for closure without being reviewed by a medical consultant, PC cases being recommended for referral to investigation, and complaints being recommended for closure due to insufficient evidence. In addition, he assists with medical records procurement issues, performs undercover investigations of suspected Internet prescribing violations, serves as a liaison between MBC and other health care agencies, designs and teaches training courses for CCU analysts and MBC investigators, reviews proposed updates to various MBC procedure manuals, and assists in the recruitment of new medical consultants and expert reviewers. Both MBC and HQE agree that the addition of this expertise has had a beneficial effect on the functioning of CCU.

Detection of physician misconduct: sources of complaints and reports. Unlike other occupational licensing agencies, MBC is not solely dependent on consumers for information about physician misconduct. For many years, the California Legislature has mandated that other institutions — including medical malpractice insurance carriers, courts, hospitals, coroners, and physicians themselves — file reports with MBC about events that may indicate a problem physician. Exhibit V-C above presents an itemized breakdown of "B&P Mandated Reports" — reports that are required to be filed by the "mandatory reporting scheme" in Business and Professions Code section 800 *et seq*.[104]

Exhibit VI-A below presents a breakdown of all complaints received by MBC in 2004–05, by referral source, and the percentage of complaints submitted by each source that was referred for investigation and prosecution (either by HQE or by local prosecutors).

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and investigatory unit of MBC. Due to staffing shortfalls and budget constraints, HQE did not post any DAGs at MBC's investigative offices until January 1, 1997. Although a brief and limited effort to provide DAG guidance to CCU was attempted in 1991–93, HQE did not assign any DAG to work in CCU until October 1, 2003 — shortly before the MBC Enforcement Monitor project began. *Initial Report*, *supra* note 13, at 31, 40–41, 54, 81–82.

[104] *See id*. at 84–86 for a detailed description of MBC's mandatory reporting scheme.

Ex. VI-A. FY 2004–05 Physician Complaint Processing and Investigations by Referral Source

Referral Source	FY 2004–05								
	Complaints Received	Reviewed By Medical Consultant	Complaints Closed By CCU	Referred to Investigation		Non-Legal Closures	Legal Closures		
				Number	Percent		Attorney General*	District Attorney*	Percent
Patient, Patient Advocate, Family Member or Friend	4,360	1,016	4,216	412	9%	322	111	9	27%
Out of State Medical/Osteopathic Boards	438	0	328	97	23%	5	95	0	95%
Section 801, 801.1 & 803.2 (Insurers & Employers)	725	576	597	193	24%	150	55	0	27%
Section 805 (Health Facilities)	112	0	29	83	74%	67	33	0	33%
Department of Health Services	103	12	75	38	34%	24	12	1	35%
M.D. Licensees	208	9	190	44	19%	35	7	0	17%
DOJ - Criminal Identification & Information Bureau (CII)	230	1	226	56	20%	40	16	0	29%
Other Governmental Agencies	69	10	50	40	44%	17	7	2	35%
Anonymous	270	2	257	32	11%	35	9	2	24%
Insurance Company	48	0	36	7	16%	10	2	0	17%
Police/Sheriff Departments	42	0	17	26	60%	11	8	3	50%
Section 802 & 802.1 (Self-Reporting)	207	218	192	67	26%	38	8	0	17%
Other	80	0	64	16	20%	17	3	1	19%
Newsclipping	7	1	2	6	75%	5	2	0	29%
Section 803 & 803.5 (Courts)	22	11	20	3	13%	1	0	0	0%
Employee or Co-worker of Subject	55	1	37	22	37%	11	6	1	39%
Pharmacist or Employee	18	0	11	6	35%	7	2	1	30%
Attorney General & Dept. of Justice	7	0	2	5	71%	3	0	0	0%
Coroner (including Section 802.5)	23	21	18	10	36%	11	2	0	15%
Confidential Informant	26	0	17	7	29%	3	2	1	50%
B&P 2240(A) - Self-Reported Surgical Complications	11	9	7	5	42%	2	1	0	33%
District Attorney	11	0	3	8	73%	3	3	0	50%
Allied Health Licensee	10	0	7	3	30%	1	0	0	0%
Other DCA Boards and Bureaus	16	4	24	5	17%	6	0	1	14%
Other Healing Arts Licensee	14	1	15	0	0%	1	2	1	75%
Hospital (Non-805 Report)	6	4	6	3	33%	3	0	0	0%
Jury Verdict Weekly	2	1	1	2	67%	1	0	0	0%
Court Clerk - Non-Felony Conviction	9	0	9	0	0%	1	0	0	0%
WE Tip	21	0	18	1	5%	1	0	0	0%
Medical Society or Association	12	0	11	1	8%	0	0	0	0%
Total, Excluding Medical Board	7,162	1,897	6,485	1,198	16%	831	386	23	33%
Medical Board	343	14	112	236	68%	121	135	11	55%
Total, Including Medical Board	7,505	1,911	6,597	1,434	18%	952	521	34	37%

* May include dual referrals.

Source: Medical Board of California

The data in Exhibit VI-A are consistent with similar data presented in the *Initial Report*,[105] and — once again — we can draw several conclusions from them. First, the predominant source of complaints is patients, their advocates, and their families. However, those complaints are rarely referred for investigation — only 9% of patient complaints went to investigation during 2004–05, which is consistent with 2003–04 (9% of patient complaints referred for investigation) and 2002–03 (11% of patient complaints referred for investigation). During 2004–05, the principal sources of complaints referred for investigation were mandatory reports required by Business and Professions Code section 800 *et seq*., especially section 805 reports of adverse peer review action taken by

[105] *Id*. at 87.

hospitals (74% of section 805 reports were referred for investigation), section 802.5 reports by coroners (36% referred), section 802/802.1 self-reporting by physicians (26% referred), and section 801/801.1/803.2 reports by insurers and employers regarding malpractice payouts (24% referred). Other high-yield sources are medical and osteopath boards in other states, other government agencies, and local police or sheriff departments.

Disciplinary actions taken in section 2220.05 priority cases. As described above, SB 1950 (Figueroa) imposed mandatory case processing priorities on MBC. It also required the Monitor to assess "the relative value to the board of various sources of complaints or information available to the board about licensees in identifying licensees who practice substandard care causing serious patient harm . . . ."[106] In the *Initial Report*, the Monitor was required to present "an analysis of the sources of information that resulted in each disciplinary action imposed since January 1, 2003, involving priority cases, as defined in Section 2220.05."[107] The Monitor presented that analysis for the period of January 1, 2003 through June 30, 2004 in the *Initial Report*; those figures are reproduced in Exhibit VI-B below. The exhibit provides the total number of disciplinary actions taken in both section 2220.05 priority categories and in MBC's pre-existing "urgent/high/routine" categories which are still used to prioritize cases not falling within section 2220.05. Exhibit VI-B indicates that, during the 18-month period surveyed in the *Initial Report*, 24% of MBC disciplinary actions taken were in priority cases under section 2220.05, and that — in raw numbers — patients were the top source of section 2220.05 priority complaints resulting in disciplinary action.

Exhibit VI-B also supplements the 18-month period described in the *Initial Report* with another year's worth of data. Between July 1, 2004 and June 30, 2005, 29% of MBC disciplinary actions taken were in section 2220.05 priority cases — representing an upward trend since the period charted in the *Initial Report*. As during the first reporting period, patients were once again — in raw numbers — the top source of priority complaints resulting in disciplinary action.

The Business and Professions Code section 800 *et seq*. "mandatory reporting statutes" continue to be high-yield sources of information leading to disciplinary actions in priority cases. Of the 218 disciplinary actions taken in section 2220.05 priority cases during the 30-month period covered in Exhibit VI-B, 31% resulted from mandatory reporting. This is consistent with the data in Exhibit VI-A above.

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[106] Bus. & Prof. Code § 2220.1(c)(2).

[107] *Id*. § 2220.1(d).

Ex. VI-B. Disciplinary Actions by Referral Source by Priority

Referral Source	1/1/03 through 6/30/04			7/1/04 through 6/30/05			Total		
	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total
Out-of-State Medical/Osteopathic Boards	0	109	109	0	83	83	0	192	192
Medical Board	15	69	84	9	51	60	24	120	144
Patient, Patient Advocate, or Family Member	24	44	68	27	26	53	51	70	121
B&P 801 and 801.1 Reports (Insurers)	14	23	37	24	20	44	38	43	81
B&P 805 Reports (Heath Care Facilities)	17	27	44	7	19	26	24	46	70
Department of Health Services	5	20	25	3	17	20	8	37	45
M.D., Other Healing Arts Licensee, Medical Assoc.	4	13	17	9	8	17	13	21	34
Other Government Agencies	3	12	15	3	6	9	6	18	24
Anonymous	5	7	12	6	3	9	11	10	21
Other (confidential informant, coworker, employee, other)	7	10	17	3	1	4	10	11	21
DOJ CII Report	0	8	8	0	12	12	0	20	20
Insurance Company	3	8	11	1	4	5	4	12	16
Police/Sheriff's Department	6	3	9	3	2	5	9	5	14
B&P 802 Reports (Self-Reporting)	2	8	10	2	0	2	4	8	12
Drug Enforcement Administration	4	2	6	1	0	1	5	2	7
B&P 803 Reports (Courts)	1	3	4	1	0	1	2	3	5
Pharmacist or Employee	2	1	3	1	1	2	3	2	5
Department of Justice	0	0	0	1	2	3	1	2	3
District Attorney	2	1	3	0	0	0	2	1	3
2240(a) Self-Reported Surgical Complications	0	0	0	1	1	2	1	1	2
Coroner's Office	0	0	0	1	1	2	1	1	2
Court Clerk - Non-felony	0	0	0	1	0	1	1	0	1
Total	114	368	482	104	257	361	218	625	843
Percent	24%	76%	100%	29%	71%	100%	26%	74%	100%

Source: Medical Board of California

Of the 843 disciplinary actions taken during this 30-month period, 218 (26%) were taken in section 2220.05 priority cases, and 625 (74%) were taken in nonpriority cases. However, this does not support a conclusion that "74% of MBC's disciplinary actions were taken in cases where there was no patient harm."

As noted in the *Initial Report*, MBC is taking disciplinary action in more patient harm cases than the data indicate. The most fruitful source of complaints in which disciplinary action was taken during the 30-month period was out-of-state medical boards and osteopathic medical boards. Twenty-three percent (23%) of the 843 disciplinary actions taken by MBC resulted from out-of-state disciplinary action. However, none of these cases was classified as a section 2220.05 priority case.

This is a function of the way MBC codes incoming reports of out-of-state physician discipline. Even though many out-of-state disciplinary actions upon which MBC's subsequent disciplinary action was premised involved "death or serious bodily injury" to a patient (such that they conceivably could have been classified as U1 priorities), technically MBC is not reopening those cases, rehearing the evidence, and taking disciplinary action for death or serious bodily injury — instead, it is basing its own disciplinary action on the other state's disciplinary action.[108] As such, all 192 cases were coded as "routine." Although MBC might have coded those out-of-state disciplines involving death or injury as U1 in order to "pad" its statistics, it did not. This decision is probably appropriate. Many of the physicians disciplined in this category do not reside in California and pose little threat to California consumers; they reside in another state (where they committed the act resulting in discipline) but also have a California license.

The Medical Board itself was the second most productive source of complaints leading to all disciplinary actions taken since January 1, 2003. The Medical Board is considered the "source" of complaints leading to disciplinary action in a number of different scenarios — several of which portend likely patient harm: (1) CCU or a district office investigator is investigating a case against Dr. X, obtains medical records and — based on the records — realizes that Dr. Y is equally or more culpable, and initiates a complaint against Dr. Y; (2) when an investigator is looking into a case, she will often run a "Civil Index" check (a check on all civil malpractice actions filed against the subject physician) and may find additional victims of the subject physician who have not filed a complaint with MBC, whereupon the investigator will initiate a new complaint against that physician; (3) if a physician whose license is on probation violates the terms of that probation and MBC files a petition to revoke the probation, MBC is listed as the source of the complaint leading to the petition; (4) when a physician whose license has been revoked petitions for reinstatement of his license, the physician's post-revocation conduct and rehabilitation is the subject of an investigation by a district office investigator, and MBC is listed as the source of that investigation; (5) when a self-referred participant in the Diversion Program is terminated for failure to comply with his/her Diversion contract, MBC is listed as the source of that action; (6) if a physician who is on probation decides to simply surrender his/her license, MBC is listed as the source of that surrender; and (7) occasionally, when MBC is investigating an allegation of unlicensed practice, it finds a physician who is aiding and abetting the unlicensed practice and initiates a complaint against that physician. Thus, in addition to taking disciplinary action in section 2220.05 priority cases, MBC is also taking disciplinary action in "patient harm" cases that fall outside section 2220.05's categories.

[108] *See id.* § 2305 (most disciplinary actions taken by another state or jurisdiction are grounds for disciplinary action in California).

B. The Monitor's Findings and MBC/Legislative Responses

The following summarizes the Monitor's *Initial Report* findings and concerns about CCU's performance, and documents the responses to those findings implemented by the Medical Board, the Attorney General's Office, and the Legislature during 2005. More detail on each of the findings is available in Chapter VI of the *Initial Report*.[109]

1. CCU's average complaint processing time is longer than historically reported.

In the *Initial Report*, the Monitor noted that MBC had been counting as "complaints" several categories of information that should not be counted as complaints — including "notices of intent (NOI) to sue" under Code of Civil Procedure (CCP) section 364.1, copies of insurer reports of malpractice payouts sent to the National Practitioner Data Bank (NPDB), and "change of address citations."[110] As a result, CCU's reported complaint total was artificially high and its reported average complaint processing time was artificially low. The Monitor recommended that MBC discontinue counting all three types of notices as "complaints."[111]

In 2003–04, MBC discontinued counting NOIs and NPDB reports as complaints.[112] In 2004–05, MBC discontinued counting "change of address citations" as complaints.[113] Similarly, they have been excluded from MBC's calculation of CCU's average complaint processing time. Thus, MBC has fully implemented the Monitor's recommendations and is accurately reporting both its complaint/report intake and its average case cycle times.

Related to this issue, the Monitor recommended (Recommendation #6) that CCP section 364.1 be repealed, as these reports provide MBC with information that is of little or no use. Effective January 1, 2006, section 20 of SB 231 (Figueroa) repeals section 364.1.

2. CCU's complaint processing takes too long.

In the *Initial Report*, the Monitor excluded NOIs, NPDB reports, and change of address citations from the calculation of CCU's average complaint processing, and found that it took CCU

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[109] *Initial Report*, *supra* note 13, at 97–117.

[110] *See supra* note 85.

[111] *Initial Report*, *supra* note 13, at 117 (Recommendation #5).

[112] *Id*. at 98.

[113] Medical Board of California, *2004–05 Annual Report* (Oct. 1, 2005) at v.

an average of 79 days (2.63 months) from receipt of a complaint to its closure or referral to the field for investigation during 2003–04 — 12 days longer than it took CCU to process complaints in 2002–03.[114] Exhibit VI-C below indicates that during 2004–05, CCU lowered its average complaint processing time to 66 days (2.2 months) — an encouraging 16% decrease.

Ex. VI-C. FY 2004–05 CCU Physician Complaint Processing Timeframes by Disposition and Day Range

Day Range	Closed By CCU[1]		Referred to Investigation[2]		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	2,660	41.0%	699	48.7%	3,359	42.4%
1 to 2 Months	1,275	19.6%	195	13.6%	1,470	18.6%
2 to 3 Months	901	13.9%	133	9.3%	1,034	13.0%
3 to 4 Months	575	8.9%	94	6.6%	669	8.4%
4 to 6 Months	664	10.2%	171	11.9%	835	10.5%
More than 6 Months	415	6.4%	142	9.9%	557	7.0%
Total, Excluding Change of Address Citations	**6,490**	**100.0%**	**1,434**	**100.0%**	**7,924**	**100.0%**
Average Timeframe	**64 Days**		**68 Days**		**66 Days**	

[1] Includes 26 complaints that took longer than a full year.

[2] Includes 12 complaints that took longer than a full year.

Source: Medical Board of California

Also in the *Initial Report*, the Monitor examined the time it takes CCU to process quality of care complaints — the thrust of SB 1950 (Figueroa). As described above, QC complaint processing generally involves (1) a CCU request for the patient's signature on a release; (2) a CCU request for the patient's medical records; and (3) review of those medical records and other materials submitted by the subject physician by a "specialty reviewer" under Business and Professions Code section 2220.08. In 2003–04, the average time from receipt of a QC complaint to completion of the medical consultant's review was 140 days (4.66 months). Approximately ten of these days were consumed by complaint receipt and initiation, medical records procurement took 66 days, and the time consumed by the "specialty reviewer" was 64 days.[115]

Monitor's Recommendations #7, #23, and #34 focused on one of the most pervasive and unnecessary delays in the enforcement program — the excessive amount of time it takes MBC and HQE to request and receive medical records which are indispensable in proving a quality of care case — and the apparent toleration of that delay in physician compliance with medical records laws on the part of both MBC and HQE personnel. These recommendations urged MBC and HQE to agree to and strictly enforce a new medical records procurement policy that encourages prompt production of requested medical records. For its part, CCU consulted with its assigned deputy attorney general in April 2005 and revised section 5.5 of the *CCU Procedure Manual* in July 2005. The manual

[114] *Initial Report*, *supra* note 13, at 99 (Ex. VI-H).

[115] *Id*. at 100–01.

revisions emphasize the statutory timeframes for production of requested medical records and revamp the request letters sent by CCU to physicians and medical facilities to include a citation to the relevant statute, a copy of the statute, and reference to possible penalties for noncompliance.[116]

CCU's emphasis on prompt medical records procurement appears to have worked. In 2004–05, CCU's average QC complaint processing time dropped to 122 days — a 13% decrease from 2003–04. Whereas the complaint initiation and specialty reviewer components remained approximately the same, the medical records procurement component of CCU processing was cut from 66 days to 48 days.

Thus, in the past year, CCU's overall complaint processing time has dropped by 16% to 66 days, and its QC complaint processing time has dropped 13% from 140 days to 122 days. While laudable, these timeframes — especially the QC complaint timeframe — are still excessive in the context of Business and Professions Code section 2319's statutory goal of 180 days from receipt of a complaint until completion of the investigation. CCU should continue to work hard on reducing the time spent on medical records procurement and specialty review (discussed in more detail below).

Related to medical records, Monitor's Recommendation #8 suggested an expansion of the role of the assigned CCU DAG, and encouraged MBC to make better use of the DAG to assist with medical records procurement issues. Both MBC and HQE agree that the assigned DAG's presence in and contributions to CCU have been valuable. Regrettably, however, HQE's staffing losses and overall workload required HQE, in May 2005, to return the assigned CCU DAG to its Sacramento office for accusation filing and trial work. HQE hopes to reinstate the DAG in CCU by January 1, 2006, and also hopes — with the fee increase in SB 231 — to assign a DAG full-time to CCU (or to assign two DAGs half-time to CCU) to assist with case disposition review, medical records procurement, and stubborn issues related to malpractice payout reporting by insurance companies and physician employers (see below).

3. CCU's implementation of the specialty review requirement for QC complaints has caused a number of problems.

As described above, SB 1950 (Figueroa) added section 2220.08 to the Business and Professions Code, which requires CCU — before referring most QC complaints to the field for investigation — to ensure they have been "reviewed by one or more medical experts with the

[116] As described in Chapters VII and IX below, MBC's *Enforcement Operations Manual* was also revised to include a new "zero tolerance" policy on the part of investigators and prosecutors toward noncompliance with medical records statutes, and HQE mailed dozens of letters to defense attorneys and physician organizations announcing the new policy.

pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required." As noted above, this mandate required CCU to recruit and train a number of new reviewers in niche subspecialties — not an easy task when CCU is able to pay only $75 per hour.

In the *Initial Report*, the Monitor found that the specialty review requirement was being implemented rather strictly by CCU, and that method of implementation was causing substantial delay in the processing of QC cases in certain specialties (including neurology, radiology, and cardiology). Specifically, we compiled data on all reviews completed by CCU medical consultants during calendar year 2003, and separated our analysis into two categories: (1) "high-volume specialties" — those specialties that are often the subject of complaints and in which CCU has a number of trained and experienced reviewers, and (2) "low-volume specialties" — specialties and subspecialties in which relatively few physicians practice and/or are less often the subject of complaints, and in which CCU has no (or very few) trained and experienced reviewers. We found that specialty reviews in high-volume specialties during calendar year 2003 were completed in an average of 35 days, while reviews in low-volume specialties were completed in an average of 69 days. Further, we found a large and growing backlog of pending and unassigned cases — portending a significant delay in the processing of QC cases.

Finally, the Monitor found that the specialty review requirement was costly in other ways — (1) CCU was "raiding" MBC's expert reviewer list to find specialists qualified to perform a specialty review (thus depriving district offices of their use later on in the proceeding); (2) CCU was forced to pay physicians on the expert reviewer list $100 per hour for reviewing CCU cases instead of its usual $75 per hour salary; and (3) it was not clear that either the quality of the reviews or fairness to physicians had improved due to the use of specialty reviewers. Between 2000 and 2003, fewer reviews were accomplished in a longer time, yet approximately the same proportion of cases was referred for formal investigation each year, and MBC district office medical consultants found little or no improvement in the quality of the CCU reviews.[117]

In the *Initial Report*, the Monitor made three recommendations relating to specialty review: (1) MBC should revisit its implementation of section 2220.08 and identify alternative specialists who are also qualified to review cases in a narrow subspecialty; (2) section 2220.08 should be amended to permit MBC to refer a given case to a generalist reviewer if it is unable to locate a specialty reviewer after a 30-day good faith search; and (3) section 2220.08 should be amended to exempt from the specialty review requirement new complaints against physicians who are already the subject of a formal investigation, a filed accusation, or on probation (Recommendations #9 and #10). These recommendations have been implemented as follows:

[117] *Initial Report*, *supra* note 13, at 101–06.

■ ***Alternative specialists***. In a memo dated June 21, 2005, MBC informed the Monitor that CCU has developed a protocol for utilizing a qualified alternative medical reviewer in some cases where a subspecialist cannot be found to review a complaint after a 30-day good faith search. CCU's protocol was reviewed and approved by its lead medical consultant, a district office medical consultant, MBC's enforcement chief, and MBC's executive director, and it provides CCU with a reasonable approach to securing qualified medical review of QC cases without undue delay. The protocol includes the following chart listing recommended alternative specialists where a QC complaint focuses on a particular specialty.

Ex. VI-D. CCU Protocol Regarding Alternative Specialist Reviewers

Medical Specialty	Recommended Alternate MC Review
Allergy and Immunology	Internal Medicine, Family Practice
Anesthesiology	General Surgery
Cardiology - Medication Management Only	Internal Medicine, Family Practice
Cardiology - Surgical care	General Surgery
Cardiothoracic Surgery	General Surgery
Dermatology	Internal Medicine, Family Practice
Emergency Medicine	Family Practice
Endocrinology	Internal Medicine
ENT/Otolaryngology	Internal Medicine or General Surgery (depending on issue)
Facial, Plastic, Reconstructive Surgery	General Surgery
Gastroenterology	Internal Medicine, Family Practice
Hematology / Oncology	Internal Medicine
Internal Medicine	Family Practice
Nephrology	Internal Medicine
Neurological Surgery	General Surgery
Neurology	Internal Medicine
OB/ GYN	Family Practice
Ophthalmology	Family Practice (if not surgical case)
Orthopedic Surgery	General Surgery
Orthopedic	Family Practice
Pain Medicine	Internal Medicine, Family Practice
Pathology	No Recommendation
Perinatal / Neonatology	Pediatrics
Physical / Rehabilitation Medicine	Internal Medicine, Family Practice
Psychiatry	Internal Medicine (medication issues)
Pulmonary / Critical Care	Internal Medicine
Radiology	No Recommendation
Rheumatology	Internal Medicine
Spine Surgery	Orthopedic Surgery/General Surgery
Thoracic Surgery	General Surgery
Urology	Internal Medicine, Family Practice

Source: Medical Board of California (11/1/05)

■ ***Amendment of section 2220.08 to exempt complaints from specialty review after 30-day search***. Both the Medical Board and the Monitor agreed to postpone consideration of this recommendation based on representations by enforcement staff at MBC's February 2005 meeting that (1) CCU was developing the protocol described above, and (2) CCU had successfully recruited and trained a sufficient number of specialty reviewers such that the average time delay had declined significantly. We gathered additional data on the time consumed by specialty review during calendar years 2004 and 2005 (through September 15, 2005); these data are reflected in Exhibit VI-E below.

Ex. VI-E. CCU Medical Consultant Reviews

Specialty	CY2003				CY2004				2005 (through September 15)			
	Total Cases	Days Unassigned (Average)	Days Assigned (Average)	Total Days (Average)	Total Cases	Days Unassigned (Average)	Days Assigned (Average)	Total Days (Average)	Total Cases	Days Unassigned (Average)	Days Assigned (Average)	Total Days (Average)
Allergy and Immunology				0	1	7	29	36	19	23	42	65
Anesthesiology	28	32	39	71	47	67	21	88	19	23	42	65
Cardiology	52	60	28	88	54	87	49	136	24	51	46	97
Cardiothoracic/Thoracic Surgery	0	0	0	0	11	61	28	79	6	15	9	24
Colon and Rectal Surgery	0	0	0	0	0	0	0	0	1	4	11	15
Dermatology	18	71	20	91	35	43	25	68	17	26	50	76
Endocrinology	2	87	30	117	2	63	33	96	3	10	32	42
ENT/Otolaryngology	25	49	16	65	6	55	28	83	10	29	20	49
Gastroenterology	21	22	21	43	28	16	31	47	21	16	30	46
Hematology/Oncology	10	52	22	74	67	79	69	148	12	61	46	107
Internal/General Medicine	798	12	21	33	727	40	28	68	276	11	20	31
Midwife	0	0	0	0	6	56	35	91	0	0	0	0
Nephrology	3	0	31	31	2	62	16	78	2	14	14	27
Neurological Surgery	10	23	14	37	26	65	24	89	8	28	13	41
Neurology	3	61	22	83	24	78	19	97	7	62	21	83
Obstetrics and Gynecology	177	16	28	44	197	12	24	36	83	9	29	38
Ophthalmology	54	27	23	50	75	48	34	82	31	36	28	64
Orthopedic and Spine Surgery	45	58	26	84	161	26	15	41	54	9	8	17
Orthopedics	48	43	21	64	62	25	8	33	32	9	8	17
Pain Medicine	7	55	8	63	18	28	48	76	4	27	43	70
Pathology	2	80	14	94	4	97	112	209	2	90	11	101
Pediatrics	67	15	23	38	70	30	31	61	35	11	25	36
Perinatal/Neonatal	3	82	38	120	7	69	28	97	4	22	27	49
Physical Medicine and Rehabilitation	11	111	15	126	4	54	26	80	4	23	39	62
Plastic/Reconstructive Surgery	52	30	20	50	116	36	28	64	56	20	40	60
Psychiatry	84	10	20	30	42	46	41	87	15	35	41	76
Pulmonology	8	24	30	54	8	59	29	88	8	17	17	34
Radiology	54	41	26	67	75	76	27	103	35	40	23	63
Rheumatology	2	40	28	68	2	76	42	118	2	33	22	55
Surgery	147	25	16	41	195	13	10	23	99	5	10	15
Urology	25	68	21	89	58	77	24	101	23	43	29	72
Total	**1,756**	**23**	**22**	**45**	**2,130**	**40**	**27**	**67**	**912**	**27**	**26**	**53**

Source: Medical Board of California

As is clear from Exhibit VI-E, the specialty review requirement is still causing significant delay in a large number of specialties. The overall 2003 average of 45 days sharply increased to 67 days in 2004, and has eased back to 53 days in 2005 to date. Additionally, the data do not shed light on whether specialty review is improving the quality of medical review of QC cases and/or fairness to physicians. Exhibit VI-F below reveals that, although the number of cases referred for specialty review has declined dramatically, the proportion of complaints referred for formal investigation between 2000 and 2004 has not declined at all; if anything, it has increased (but not to a significant degree).

Ex. VI-F. CCU Disposition of Physician Complaints Following Medical Consultant Review

Disposition	3-Year Average for CYs 00, 01, 02		CY 2003		CY 2004	
	Number	Percent	Number	Percent	Number	Percent
Closed (no violation)	1,852	61.5%	1,460	61.3%	1,201	57.4%
Closed (insufficient evidence)	486	16.1%	354	14.9%	338	16.2%
Closed (info on file)	49	1.6%	61	2.6%	83	4.0%
Closed - Other	29	1.0%	30	1.3%	13	0.6%
Subtotal	2,415	80.2%	1,905	79.9%	1,635	78.2%
Referred to INV	596	19.8%	478	20.1%	457	21.8%
Total	3,011	100.0%	2,383	100.0%	2,092	100.0%

Source: Medical Board of California

■ ***Other exemptions from specialty review***. As recommended by the Monitor, section 12 of SB 231 (Figueroa) exempts from the section 2220.08 specialty review requirement new complaints against physicians who are already under investigation, the subject of a pending accusation, or on probation.

4. The codification of mandatory case processing priorities is resulting in unintended consequences.

As noted above, SB 1950 (Figueroa) added section 2220.05 to the Business and Professions Code , which requires MBC to "prioritize its investigative and prosecutorial resources to ensure that physicians . . . representing the greatest threat of harm are identified and disciplined expeditiously." The statute says that complaints falling into one of five stated categories (coded "U1–U5" by MBC) — which attempt to capture physicians "representing the greatest threat of harm" — should be handled on a priority basis. No one quarrels with this sound goal. However, as noted in the *Initial Report*, the statute has caused unintended consequences:

■ ***Overuse of U1 priority***. One net effect of the statute has been the elevation of all cases where there has been a death or "serious bodily injury"[118] to a patient to U1 status ("gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public"). Exhibit VI-G below arrays the 7,505 complaints and reports against physicians by referral source and by priority as assigned by CCU:

Ex. VI-G. FY 2004–05 Physician Complaints Received by Priority by Referral Source

Referral Source	U1 Death or Serious Injury	U3 Excessive Prescribing	U4 Sexual Misconduct	U5 Prctng. Under the Influence	Subtotal Priority U1–U5	Urgent	High	Routine	Total
Patient, Patient Advocate, Family Member or Friend	651	86	91	2	830	474	798	2,258	4,360
Section 801, 801.1 & 803.2 (Insurers & Employers)	718	0	3	0	721	0	4	0	725
Section 802 & 802.1 (Self-Reporting)	199	0	0	0	199	5	0	3	207
Anonymous	11	8	8	6	33	71	6	160	270
M.D. Licensees	11	5	4	2	22	33	11	142	208
Department of Health Services	11	2	1	0	14	18	17	54	103
Coroner (including Section 802.5)	21	0	0	0	21	2	0	0	23
Police/Sheriff Departments	2	5	14	0	21	14	2	5	42
Other Governmental Agencies	7	12	0	0	19	36	12	0	67
B&P 2240(A) - Self-Reported Surgical Complications	11	0	0	0	11	0	0	23	34
Employee or Co-worker of Subject	0	2	3	3	8	14	1	32	55
Section 803 & 803.5 (Courts)	14	0	0	0	14	6	2	0	22
Section 805 (Health Facilities)	3	0	2	0	5	93	0	14	112
Insurance Company	0	4	1	0	5	4	5	34	48
Attorney General & Department of Justice	1	1	0	0	2	1	2	2	7
Pharmacist or Employee	0	6	0	0	6	3	3	6	18
Other	1	5	1	0	7	0	7	46	60
Out of State Medical/Osteopathic Boards	0	0	2	0	2	6	0	430	438
Newsclipping	0	0	0	0	0	2	4	1	7
Confidential Informant	3	2	0	0	5	11	0	10	26
Other Healing Arts Licensee	0	1	1	0	2	2	1	9	14
WE Tip	0	1	0	0	1	10	1	9	21
Other DCA Boards and Bureaus	1	0	0	0	1	9	0	5	15
District Attorney	1	2	0	0	3	5	2	1	11
DOJ-Criminal Identification & Information Bureau (CII)	0	0	0	0	0	72	156	2	230
Allied Health Licensee	1	0	0	0	1	2	3	4	10
Medical Society or Association	0	0	0	0	0	0	0	12	12
Hospital (Non-805 Report)	0	0	0	0	0	2	3	1	6
Court Clerk - Non-Felony Conviction	0	0	0	0	0	0	9	0	9
Jury Verdict Weekly	2	0	0	0	2	0	0	0	2
Total, Excluding Medical Board	1,669	142	131	13	1,955	895	1,049	3,263	7,162
Medical Board	45	15	14	1	75	101	25	142	343
Total, Including Medical Board	1,714	157	145	14	2,030	996	1,074	3,405	7,505

Source: Medical Board of California

Thus, of 7,505 complaints received in 2004–05, 2,030 (27%) were classified as section 2220.05 priority complaints. And of the 2,030 priority complaints, 1,714 (84%) were classified as

[118] The term "serious bodily injury" is not defined in section 2220.05 or any other California statute; thus, CCU's classification of complaints involving injury is necessarily subjective. In an attempt to comply with the intent of the statute, CCU assigns a U1 priority to almost every complaint or report involving injury to a patient.

U1 complaints.[119] In 2004–05, most section 2220.05 priority cases were U1; as in 2003–04, there were no U2s (because the U2 category is subsumed by U1), and relatively few U3s, U4s, and U5s.[120] Not everything can be assigned a U1 priority. If everything is a U1 priority, in effect we have no priority system. But almost every priority case is classified as a U1 priority in the present system.

■ ***Lower priority for cases posing imminent harm***. Both the language of the statute and the way in which MBC has implemented the section 2220.05 priorities have elevated *patient outcome* over factors which may be as or more important in enforcement circumstances, including imminence of harm, strength of evidence, and culpability. Patient injury or death is always tragic. Sometimes it is the fault of the doctor; many times it is not. But the mere presence of a tragic outcome should not necessarily dictate prioritization of enforcement activity. A good argument can be made that it is more important for MBC to move quickly on a complaint of recent egregious sexual misconduct (U4) or practicing while impaired (U5) rather than a section 801 report of a civil settlement involving the death of a patient five years ago (U1). A good argument can likewise be made that a felony conviction, aiding and abetting unlicensed practice in backroom clinics, and even some probation violations — none of which are included in section 2220.05's list of priorities deserve more expedited treatment than a stale 801 report of a civil settlement stemming from a death five years ago.

■ ***No priority for economic harm cases***. Adequate protection of the California public also requires an enforcement presence in other important areas of medical misconduct. No one disputes that a death is a greater tragedy than economic harm or non-fatal unlicensed practice, but a system which inhibits MBC from bringing at least some actions to stop economic harm or unlicensed conduct sends a dangerous signal that such misconduct is tolerated in California. Today, fraud (including egregious insurance fraud that does critical systemic damage to our health care system) and deceptive business practices which injure honest practitioners and consumer victims are relegated to a very low priority by MBC in its current interpretation of its mandate.

In the *Initial Report*, the Monitor noted the good intentions behind the statute, and the extraordinary difficulty of transferring those intentions into words. The Monitor also noted that —

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[119] These figures are almost identical to MBC's 2003–04 statistics, when 28% of incoming complaints were classified as section 2220.05 priority complaints, and 85% of them were assigned a U1 priority. *Initial Report*, *supra* note 13, at 106–09.

[120] Further, 917 of the 1,714 U1 complaints (53%) are section 801/801.1/802/803.2 reports of civil malpractice settlements, which often occur several years after the event that prompted the lawsuit. In cases where three or four years have elapsed since the event and the physician has not been the subject of any subsequent complaint or report, it is not appropriate to classify the complaint as U1 because the physician is not "a danger to the public" as required in section 2220.05(a)(1). However, that is a judgment call and MBC has chosen to err on the side of caution and demonstrate absolute compliance with the letter and spirit of the statute.

contrary to frequent arguments by defense counsel — the statute does not say that MBC may investigate, prosecute, and take disciplinary action only in cases falling into one of the five priority categories; nor does it say that MBC may not investigate, prosecute, and take disciplinary action in cases falling outside the five categories. In Recommendation #11, the Monitor suggested that all stakeholders in MBC's enforcement program collaborate to refine the language of section 2220.05's "mandatory case processing priorities" to effectuate the intent of SB 1950 (Figueroa) — "ensur[ing] that physicians . . . representing the greatest threat of harm are identified and disciplined expeditiously."

At its April 22, 2005 meeting, MBC's Enforcement Committee discussed Recommendation #11 and decided to defer this issue for at least a year, rather than attempting a possibly premature legislative amendment of the statute. In the meantime, the Committee directed staff to (1) gather data on the impact of section 2220.05; (2) develop a policy statement on staff's interpretation and implementation of the statute; (3) attempt to define the statutory term "serious bodily injury"; and (4) recommend whether additional categories of priority cases should be added to the statute. At its May 6, 2005 meeting, the Division of Medical Quality approved the Enforcement Committee's recommendation.

5. Many of MBC's most important detection mechanisms are failing it.

As described above, Business and Professions Code section 800 *et seq*. sets forth an extensive "mandatory reporting scheme" intended to enable MBC to detect physician negligence, incompetence, dishonesty, and impairment so that it might investigate and take disciplinary action if appropriate. Several of these statutes have been on the books for decades — indicating strong legislative intent that MBC be notified of these events so that its discretion to investigate and its public protection mandate are furthered. As reflected in Exhibits VI-A and VI-B above, section 800 reports are valuable sources of information to the Board leading to investigation, prosecution, and disciplinary action — including disciplinary action taken in section 2220.05 priority cases. However, many of these mechanisms are failing the Board and the public.

■ ***Malpractice payouts***. Sections 801 and 801.1 require insurance companies and employers of physicians that self-insure to report to MBC specified judgments, settlements, and arbitration awards against physicians within 30 days of the event. Under section 804(b), the reports must be "complete" in that they must include eight specified items of information — including "the name and last known business and residential addresses of every physician or provider of health care services who was claimed or alleged to have acted improperly, whether or not that person was a named defendant and whether or not any recovery or judgment was had against that person." Section 804(d) further provides that insurers and self-insured employers of physicians that have received "a copy of any written medical or hospital records prepared by the treating physician or the staff of the

treating physician or hospital, describing the medical condition, history, care, or treatment of the person whose death or injury is the subject of the claim prompting the Section 801 or 801.1 report, or a copy of any depositions in the matter that discuss the care, treatment or medical condition of the person shall provide with the report copies of the records and depositions, subject to reasonable costs to be paid by the Medical Board of California to the insurer . . . ." Section 804(d) further requires insurers and self-insured governmental agencies to "maintain the records and depositions referred to in this subdivision for at least one year from the date of the Section 801 or 801.1 report."

In researching the *Initial Report*, the Monitor looked at a number of section 801 and 801.1 reports. Hardly any of them were filed within the required 30-day time period, and most of them were incomplete to the point of being almost useless to the Board (for example, many failed to identify the plaintiff in the malpractice action or the physician(s) whose conduct resulted in the payout). During our interviews of dozens of MBC and HQE staff, we were consistently told that the materials required to be forwarded to MBC by section 804 are not forwarded; in fact, on many occasions, they are destroyed as soon as the settlement is reached, making it difficult if not impossible for MBC to proceed in such a matter.

Unlike section 805 applicable to hospitals, sections 801 and 801.1 contain no penalty for failure to file the required report, failure to file a complete report, and/or failure to produce the records that are required to be produced and kept for one year from the date of the report. In Recommendation #12, the Monitor suggested that these sections be amended to include penalties for noncompliance.[121]

This is one of the few Monitor recommendations requiring legislation that was neither addressed in SB 231 (Figueroa) nor meaningfully discussed by the Medical Board in the past year. As indicated in Exhibits VI-A and VI-B above, insurer/employer reports of malpractice payouts under sections 801 and 801.1 are a reliable source of information leading to investigations and disciplinary action. In other words, proper and timely filing of these reports is an important detection mechanism for MBC. However, a number of problems beset this reporting requirement. Since the release of the *Initial Report*, CCU staff has forwarded to the Monitor numerous examples of insurer/employer reports that are late, incomplete, or that blatantly violate the letter and/or the spirit of the reporting requirement and even affect MBC's public disclosure of multiple settlements now required by Business and Professions Code section 803.1(b)(2)(A). These examples, included below, illustrate several problems that are exacerbated due to the absence of a penalty for noncompliance.

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[121] The Monitor noted that the Joint Committee on Boards, Commissions and Consumer Protection (then the Joint Legislative Sunset Review Committee) also recommended penalties on insurers "up to a $50,000 fine for a negligent failure to file, and up to a $100,000 fine for a willful failure to file" during its 2001–02 sunset review of the Medical Board. *Initial Report*, *supra* note 13, at 110.

(1) *Insurers and employers are simply not complying with the reporting requirement*. According to MBC annual reports, the number of section 801/801.1 reports filed by insurers/employers with MBC pursuant to these statutes has declined annually as follows:

Ex. VI-H. Insurer/Employer Reports of Malpractice Payouts

Fiscal Year	Number of 801/801.1 Reports Filed
1998–99	1,041
1999–00	982
2000–01	921
2001–02	872
2002–03	872
2003–04	787
2004–05	722

Source: Medical Board of California

While the number of MBC-licensed physicians residing and practicing in California grew from 80,341 in 1998 to 92,852 in 2005, Exhibit VI-H above reflects a 31% decrease in the number of these important reports filed since 1998 — and it is not because reportable events have declined or are not occurring. CCU staff often receives notices of malpractice judgments and settlements from plaintiffs, plaintiffs' attorneys, and other non-mandated reporters on events for which no report has been received from the physician's insurer or employer. CCU staff also spends a considerable amount of time reviewing newspaper articles, weekly publications, and court Web sites for information about civil judgments and settlements, and routinely finds reportable events that have not been reported.

It is clear that not all insurers and employers are reporting all settlements that must be reported. MBC staff is convinced that the public disclosure requirement for multiple malpractice settlements contained in SB 1950 (Figueroa)[122] is one significant factor that has negatively impacted settlement reporting. Additionally, several of the reporting statutes contain language that has created confusion or prompted noncompliance, as described below.

(2) *The statutory language is not always clear*. Prior to 2002, sections 801(b), 801.1(b), and 802 required reporting by insurers or employers on malpractice payouts against physicians, but contained a glaring loophole that was frequently exploited. Settlements were offered but only on the

[122] *See* Bus. & Prof. Code § 803.1(b)(2)(A).

condition that individually-named defendant physicians were dropped from the case; insured facilities or medical groups — which were generally not subject to settlement reporting requirements — then became the only settling defendants, and no report to MBC about a defendant physician was required. SB 1950 (Figueroa) attempted and intended to close this loophole by additionally requiring that "a settlement over thirty thousand dollars ($30,000) shall also be reported if the settlement is based on the licensee's negligence, error, or omission in practice, or by the licensee's rendering of unauthorized professional services, and a party to the settlement is a corporation, medical group, partnership, or other corporate entity in which the licensee has an ownership interest or that employs or contracts with the licensee." However, the new language does not expressly require such a report to identify the physician whose conduct is the reason for the payout.[123]

Predictably, insurers and employers have interpreted SB 1950's addition narrowly. For example, on April 8, 2005, an insurer reported a $250,000 malpractice settlement but announced that the physician named in the complaint had been "dismissed early in the pretrial phase of litigation." The settlement was against the physician's medical group and the insurer refused to identify the physician.

(3) *The absence of any penalty for failure to report encourages abuse and neglect.* As noted in the *Initial Report*, sections 801 and 801.1 fail to include any penalty whatsoever for insurers and employers that fail to file required reports. The following examples illustrate why the statutes should be clarified and a substantial penalty for noncompliance added:

- The carrier that insured four physicians involved in the widely-publicized events at Redding Medical Center filed one report on each physician — even though each physician settled with hundreds of plaintiffs in a "mass tort global settlement." One of these physicians settled with 654 plaintiffs, including 389 plaintiffs in excess of $30,000; although his Medical Board Web site screen should list 389 settlements, it lists none. Another Redding physician settled with 15 plaintiffs, ten of whom received in excess of $30,000; although his MBC Web site screen should list ten settlements, it lists none. Much of the information required by the statute and requested on the reporting forms — including the identities of any of the plaintiffs involved in these matters — was omitted, and both forms were filed two months late.

- The same carrier reported that two of the Redding physicians settled with multiple plaintiffs for a total of $5 million each; however, the company claims they did not settle with any individual claimant for more than $6,460 per claimant such that their settlements need not even be

[123] The drafters of SB 1950 may have believed that language expressly requiring these settlement reports to identify the physician was unnecessary because Business and Professions Code section 803.2, which incorporates by reference reports filed pursuant to sections 801, 801.1, and 801.2, already states that "[t]his report shall include the name and license number of the physician and surgeon."

reported. Again, no plaintiff identifying information was included, and the forms were filed two months late.

- A self-insured physician employer reported two settlements of $175,000 and "$1,000,000 cash + periodic payments," respectively, but refused to identify the physician whose conduct led to the payout.
- According to the Medical Board, Los Angeles County — a self-insured government agency subject to section 801.1 — has not filed any settlement reports on physician employees in over two years because it objects to the language in section 803.2 requiring it to identify the physician whose conduct led to the settlement. Recently, the County notified MBC that it has finally settled on a process by which it believes it can fairly apportion fault to individual physicians and identify them for MBC, and that it may forward to MBC its backlog of over 80 unfiled settlement reports dating back to 2003. At this writing, MBC has received none of them — and may be unable to investigate or take disciplinary action in many of them because the statute of limitations has run.
- A liability insurance carrier recently discovered that approximately 50 settlements against insured obstetrician/gynecologists dating back to 2001 have not been forwarded to MBC due to the negligence of an employee. The carrier has promised to forward them to MBC immediately; once again, however, MBC may be unable to investigate or take disciplinary action in many of them because of the statute of limitations.

(4) *Staffing and budget cuts at MBC and HQE have precluded both from promptly and comprehensively addressing this problem*. As noted above, these and other examples have been forwarded to the Monitor by CCU staff, which is well aware of this problem. However, staff is not always able to analyze the underlying problems and develop solutions — and is certainly not able to assert a remedy that does not exist. For over one year, staff has alerted MBC management of the problem, but nothing has been done about it. The loss of MBC enforcement staff, the absence of the assigned CCU DAG (although required by Government Code section 12529.5), and the separation of MBC and HQE all contribute to the stalemate on this issue.

Were there a meaningful penalty for failure to file these required reports, insurers and other mandated reporters would treat their reporting responsibilities more seriously, err on the side of caution, and file reports. Section 805, which is applicable to hospitals and their reporting of "peer review" decisionmaking, contains hefty penalties for failure to file — up to $50,000 for a negligent failure to file an 805 report, and up to $100,000 for an intentional failure to file a required report. While it is debatable whether these enhanced penalties have stimulated compliance (see below), the absence of any penalty at all renders insurers and employers absolutely unaccountable and free to do as they please — as illustrated by the examples above.

The Monitor has discussed this issue and Recommendation #12 with MBC management, who believe that tackling the problem of insurer/employer nonreporting is more difficult than hospital nonreporting. In the hospital setting, peer review is centralized within certain identifiable hospital committees and personnel, and section 805 charges those personnel (for example, "the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body") with filing the required report and explicitly subjects them to the penalty if they fail to do so. According to MBC, section 801 reports from insurance companies are not always coordinated through any single identifiable company officer, but rather come in (if they come in) from various "claims representatives." However, most companies charge a specific officer with responsibility for ultimate decisionmaking on health care liability claims, and that person could and should be identified in section 801, charged with ensuring compliance with its reporting requirement, and penalized in the event of noncompliance. Additionally, insurer noncompliance with these laws should be reported to the Insurance Commissioner and should be grounds for disciplinary action against the insurer's license.

The Monitor recognizes and appreciates the fact that MBC and HQE have expended significant time and energy addressing the vast majority of the Monitor's recommendations — both internally and in the Legislature — during 2005. However, insurer/employer failure or refusal to provide MBC with this statutorily-required information is a serious and undeniable problem which has been tolerated for too long by the Board and HQE. The Monitor recommends that MBC and HQE formulate a working group to (1) review the examples described in this report and other examples that can readily be produced by CCU staff; (2) review and draft revisions to the statutory language to close loopholes, identify mandated reporters at physician insurers and employers of all types, and add substantial penalties for noncompliance with sections 801, 801.1, 803.2, and 804; and (3) sponsor legislation enacting those amendments.

■ ***Coroner's reports***. Section 802.5 requires a coroner to file a report with MBC whenever the coroner performs an autopsy or otherwise "receives information" from a board-certified pathologist indicating that a death may be the result of a physician's gross negligence or incompetence. MBC receives very few coroner's reports — never more than 40 in a given year. In Recommendation #14, the Monitor suggested that MBC educate coroners about their reporting responsibilities. In response, MBC's public information officer sent informational letters about section 802.5 to all coroners' offices. Additionally, on September 21, 2005, MBC's enforcement chief made an hour-long presentation on MBC's enforcement program and the importance of compliance with section 802.5 to 125 members at the annual meeting of the California State Coroners' Association.

■ ***Physician self-reporting of criminal convictions***. In the *Initial Report*, the Monitor noted that section 802.1 limits physician self-reporting of criminal convictions to felonies, and questioned

why misdemeanor criminal convictions are not also required to be reported. Many misdemeanor convictions are the result of a felony charge which is pled down to a misdemeanor; others are the result of a "wobbler" charge (a crime that may be charged either as a felony or a misdemeanor in the discretion of the prosecutor) that is pled down to a misdemeanor. Many misdemeanor criminal convictions are "substantially related to the qualifications, functions, or duties" of a physician and are grounds for disciplinary action.[124] In Recommendation #13, the Monitor suggested that physicians be required to self-report all misdemeanor criminal convictions to MBC.

Section 5 of SB 231 amends Business and Professions Code section 802.1 to require physicians to self-report to MBC misdemeanor criminal convictions that are substantially related to the qualifications, functions, and duties of a physician. This self-reporting requirement will be triggered after MBC compiles, and the Legislature enacts, a list of such substantially related criminal convictions.

■ ***Court clerk reporting***. Business and Professions Code sections 803(a)(2) and 2236(c) require court clerks to report specified criminal convictions and civil malpractice judgments in any amount entered against physicians to MBC. In the *Initial Report*, the Monitor found a very low level of court clerk reporting under these statutes, primarily because (1) court clerks are unaware the reporting requirements exist; and (2) even if they know of the reporting requirement, they may not know that a criminal defendant is a physician. The Monitor noted that many other Department of Consumer Affairs agencies have similar court clerk reporting requirements, and reporting of other regulated professionals by court clerks is similarly low at other agencies. In Recommendation #15, the Monitor suggested that DCA — on behalf of all of its regulatory agencies with mandatory reporting requirements — join with the Judicial Council to design an educational program for courtroom clerks to enhance their familiarity and compliance with these reporting requirements.

During 2005, DCA's Public Affairs Office drafted an informative article regarding the various court clerk reporting requirements in the Business and Professions Code for publication in the Judicial Council's *Court News Online* electronic newsletter. Published monthly, this newsletter is widely distributed to all California courts and courtrooms. Additionally, DCA created a "universal reporting form" that can be used by any court clerk to report criminal convictions and civil judgments against any DCA licensee to the Department. DCA is preparing to publish the article and post the reporting form on its Web site. Hopefully, the article will be revised as necessary and published in the Judicial Council's newsletter at least annually, so as to improve court clerk compliance with the reporting requirements about licensees of the State of California.

[124] Bus. & Prof. Code §§ 490, 2236.

Related to reporting of civil malpractice judgments, section 4 of SB 231 (Figueroa) amended Business and Professions Code section 802 to require physicians to self-report civil judgments in any amount to the Medical Board.

■ ***Hospital reporting of adverse peer review action***. Since 1975, Business and Professions Code section 805 has required hospitals, health care facilities, and HMOs to file reports with MBC when they take certain internal disciplinary actions against physicians. The California Supreme Court has articulated the importance of the conduct of internal peer review at health care facilities and the reporting of adverse peer review actions to the Medical Board of California — whose duty is to protect "all consumers of medical services in California." The Court found that MBC's public protection mandate outweighs a hospital's interest in protecting only its own patients, and trumps a hospital's "private purpose of reducing the exposure of the hospital to potential tort liability."[125] In other words, the Court demanded compliance with section 805 because one of the purposes behind private peer review is to support MBC's public enforcement program — not the other way around.

As reflected in Exhibits VI-A and VI-B, section 805 reporting by hospitals, health care facilities, and HMOs is one of the most valuable source of complaints resulting in investigation, prosecution, and disciplinary action. However, section 805 reporting is the greatest area of failure. According to the Office of Statewide Health Planning and Development, there are 515 hospitals in California; additionally, there are numerous other health care facilities and managed care organizations that are subject to the reporting requirements of section 805. The *Initial Report* noted that, in 2003–04, MBC received only 157 section 805 reports.[126] Unfortunately, 2004–05 reporting was even lower: Only 110 section 805 reports were filed with MBC this year.[127]

To add insult to injury, the evidence indicates that compliance with section 805 is lower than it appears. In 2003–04, the Board received 157 reports — but fully one-third of those actions were taken by hospitals against a physician's privileges *after* the Medical Board disciplined the physician's license. The data for 2004–05 are similar: Of the 110 section 805 reports received, 23 reported peer review actions taken after MBC had disciplined the license of the physician. Thus, rather than peer review assisting MBC in detecting dangerous physicians as commanded in *Dal Cielo*, the tail is wagging the dog and MBC is prompting hospitals to finally take peer review action against physicians.

In 2001, SB 16 (Figueroa) attempted to stimulate compliance with section 805 in several ways. The bill increased the maximum fine for willful failure to file an 805 report from $10,000 to

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[125] *Arnett v. Dal Cielo* (1996) 14 Cal. 4th 4, 12.

[126] *Initial Report*, *supra* note 13, at 111.

[127] *See supra* Ex. V-C; *see also* Medical Board of California, *2004–05 Annual Report* (Oct. 1, 2005) at vi.

$100,000, and from $5,000 to $50,000 for other failures to file. The bill also made failure to file an 805 report by a physician reporter unprofessional conduct and grounds for disciplinary action. Importantly, SB 16 also added section 805.2, which states the Legislature's intent "to provide for a comprehensive study of the peer review process as it is conducted by peer review bodies . . . in order to evaluate the continuing validity of Section 805 and Sections 809 to 809.8, inclusive, and their relevance to the conduct of peer review in California." In his signing message, then-Governor Davis indicated his expectation that MBC would come up with the $300,000 needed to conduct the study within its existing resources. Because the Legislature failed to increase MBC's license fees since 1994 and due in part to the 2001 budget cuts, that study has never been funded and never been conducted.

In Recommendation #16, the Monitor stated that the peer review study required by SB 16 should be funded and completed as soon as possible, so that section 805 might be amended to conform its reporting requirements to the actual conduct of peer review in California. Section 6 of SB 231 (Figueroa) amends section 805.2 to require MBC to contract with an external entity to conduct the study mandated in 2001 by July 31, 2007. Under SB 231, "[c]ompletion of the peer review study . . . shall be among the highest priorities of the Medical Board of California."

■ ***Regulatory gag clauses***. In addition to the failure of the affirmative reporting mechanisms described above, CCU is often deprived of information about dangerous physicians by those very physicians when they include a "regulatory gag clause" in a civil malpractice settlement agreement. When a patient sues a physician for medical malpractice, the physician may decide to settle with the patient. However, as a condition of settlement, the physician demands inclusion of a regulatory gag clause that prohibits the patient from contacting or cooperating with the Medical Board, and/or requires the patient to withdraw a complaint pending before the Board.

Regulatory gag clauses cause many serious problems — both for the Medical Board that is being deprived of information about its own licensees by its own licensees and for unsuspecting patients who continue to be exposed to unscrupulous and/or incompetent physicians because MBC cannot take appropriate disciplinary action against them — the very antithesis of the purpose of all regulatory agencies and especially the Medical Board. Gag clauses delay the efficient processing and investigation of cases, force agencies to spend additional money to subpoena records and testimony, and have prevented some disciplinary actions altogether because the statute of limitations runs before an accusation can be filed. Regulatory gag clauses also encourage an irresponsible business model that affirmatively injures people: Despite repeated malpractice actions and repeated settlements, physicians are able to gag their victims so they cannot contact or cooperate with MBC, leaving the doctors free to turn right around and do it again — with MBC unable to do anything about it because it doesn't have a cooperative victim.

In Recommendation #17, the Monitor urged the Legislature to ban the practice of including regulatory gag clauses in civil settlement agreements. Assemblymember Gloria Negrete McLeod, Chair of the Assembly Business and Professions Committee, introduced Recommendation #17 as AB 446 (Negrete McLeod) during 2005. AB 446 replicated a 20-year-old statutory precedent applicable to attorneys,[128] and codified strong judicial precedents already applicable to teachers, physicians, and investment advisers.[129] Throughout 2005, California newspapers and national journals documented the frequency of and harm caused by regulatory gag clauses,[130] and a dozen consumer groups and state agencies (including the Medical Board and the Attorney General's Office) expressed support for the bill.

Although the Legislature passed AB 446, the Governor vetoed the bill on September 29. As noted in Chapter IV, this veto reflects a misunderstanding of the purpose of executive branch agencies, which is not to rubberstamp private dispute resolution but to protect future consumers from future injury caused by licensees of the State of California. Unfortunately, this veto perpetuates a legal loophole that is antithetical to the underlying purpose of occupational licensing agencies.

6. The staffing allocations of CCU's sections should be revisited.

In the *Initial Report*, the Monitor described the 2002 division of the Central Complaint Unit into the Quality of Care (QC) Section (consisting of a manager and seven analysts) and the Physician Conduct (PC) Section (consisting of a manager and six analysts), and noted that the initial assignment of analysts was based on the projection that MBC would receive more QC cases than PC cases.[131] As illustrated in Exhibit V-B, the reverse has been true: MBC receives more PC than QC complaints. In Recommendation #18, the Monitor suggested that CCU revisit its staffing allocations to even out caseloads, and cross-train analysts so that certain kinds of urgent PC complaints that warrant immediate attention (*e.g.*, complaints of sexual misconduct or drug/alcohol abuse) do not get lost in the massive caseloads handled by the one CCU analyst trained to handle such matters.

CCU has implemented the Monitor's recommendations. In January 2005, one analyst position was redirected from the Quality of Care Section to the Physician Conduct Section — a move

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[128] Bus. & Prof. Code § 6090.5 (originally enacted in 1986).

[129] *See, e.g.*, *Cariveau v. Halferty* (2000) 83 Cal. App. 4th 126; *Picton v. Anderson Union High School District* (1996) 50 Cal. App. 4th 726; *Mary R. v. Division of Medical Quality of the Board of Medical Quality Assurance* (1983) 149 Cal. App. 3d 308.

[130] *See*, *e.g.*, Jordan Rau, *Bill Would End Gag Clauses that Stifle Victims Who Sue*, L.A. TIMES (Apr. 19, 2005); Molly McDonough, *Second Effort Seeks to Life Contract Gag Rule*, AMER. BAR ASS'N J. (Apr. 29, 2005); *Cloaking Complaints*, RIVERSIDE PRESS-ENTERPRISE (Apr. 19, 2005); Fox News, *Hush Money for Malpractice Settlements?* (Jul. 13, 2005).

[131] *Initial Report*, *supra* note 13, at 79.

which evens out caseloads of all CCU analysts to approximately 30 new cases received each month. In addition, the redirected analyst was assigned to urgent PC matters, such that two PC analysts now handle urgent PC complaints.

7. Detection of repeated negligent acts has improved, but could be enhanced.

In the *Initial Report*, the Monitor noted that — in response to concern expressed by the Joint Legislative Sunset Review Committee during MBC's 2001–02 sunset review — CCU had instituted a review process for QC complaints that were recommended for closure because the medical consultant found only a "simple departure" from applicable standards. Under the review process, CCU's senior program analyst, lead medical consultant, and assigned CCU DAG review these cases to determine whether the complained-of physician has been the subject of prior similar complaints that were also closed as "simple departures" — such that the physician might be disciplined for repeated negligent acts under Business and Professions Code section 2234(c). In Recommendation #19, the Monitor suggested that this review process be extended to physician conduct cases as well, particularly cases alleging sexual misconduct or drug/alcohol abuse.

CCU has implemented the Monitor's recommendation. In July 2005, the Unit expanded its review process to PC cases and amended the *CCU Procedure Manual* to reflect the change. Unfortunately, the assigned CCU DAG is no longer present to participate in this review process.

8. CCU should ensure that subject physicians are notified when complaints are closed.

In the *Initial Report*, the Monitor found that CCU has done a good job of communicating with complainants throughout the screening process, but — according to the defense bar — does not always notify the subject physician that a complaint has been closed. The Monitor also found that MBC's various procedure manuals were inconsistent on this point. In Recommendation #20, the Monitor suggested that MBC ensure that physicians are notified when complaints are closed and that its procedure manuals reflect this policy.

The *CCU Procedure Manual* had always stated CCU's policy that if the subject physician has been contacted during the course of CCU's review of a complaint, the subject should be notified of its closure. In February 2005, CCU drafted new closure letters to be sent to subjects of MBC complaints that are being closed. MBC's amendment of its *Enforcement Operations Manual* on this point is discussed in Chapter VII below.[132]

[132] *See infra* note 152.

9. CCU should regularly review and update its procedure manuals.

In the *Initial Report*, the Monitor recommended that CCU ensure that its procedure manuals are regularly reviewed and revised to conform to changes in the law and MBC policy, and that HQE personnel are involved in these revisions (Recommendation #21). CCU has implemented the Monitor's recommendation; during 2005, the Monitor received five sets of revisions to the *CCU Procedure Manual*.

C. Recommendations for the Future

■ ***HQE support for CCU***. MBC and HQE must come into compliance with Government Code section 12529.5(b) by ensuring that CCU is properly staffed with attorneys "to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations." Both MBC and HQE agree that the contributions of the assigned CCU DAG have been valuable to the functioning of CCU, and the Monitor recommended an enhanced role for the CCU DAG in the *Initial Report*. The findings in this *Final Report* emphasize that the assistance of a DAG in CCU would be invaluable to assist not only with complaint disposition review but also with medical records procurement and mandatory reporting issues.

■ ***Insurer/employer reporting of malpractice payouts***. Insurer/employer compliance with the reporting requirements in Business and Professions Code sections 801, 801.1, and 803.2 is declining, and the absence of a penalty for failure to report surely encourages abuse and neglect — as described above. The Monitor recommends that MBC and HQE formulate a working group to (1) review the examples described in this report and other examples that can readily be produced by CCU staff; (2) review and draft amendments to the statutory language to close loopholes, identify mandated reporters at physician insurers and employers of all types, and add substantial penalties for noncompliance with sections 801, 801.1, 803.2, and 804; and (3) sponsor legislation enacting those amendments.